Santa Maria Valley
PHYSICAL THERAPY GROUP

Todd Martin, PT Jared Bailey, PT Samantha Stollberg, PT, PRPC
Karen Bailey, PT John Hollinshead, PT Sarada Bird, DPT
Adrian Asencio, OTR/L, CHT

Please fill out the enclosed forms and bring them with you to your first appointment. At that time, we will do a brief examination of your pelvic floor muscles, and you are welcome to bring someone with you if that would make you more comfortable. Your appointment will take place in a private room. If you have any questions prior to the appointment, please feel free to contact us at (805) 928-8257 or by email.

We understand that life gets busy and has unexpected occurrences. Please respect our time, as well as other patients. If you need to cancel or reschedule an appointment, please allow 24 hour notice. We schedule appointments so that you have our full attention.

Sincerely,

Samantha Stollberg PT, PRPC
sam@smvpt.com

Karen Bailey PT
karen@smvpt.com

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CONSENT FOR EVALUATION AND TREATMENT OF PELVIC FLOOR DYSFUNCTION

I acknowledge and understand that I have been referred to Santa Maria Valley Physical Therapy Group Inc. for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include but are not limited to urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, and vulvar or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and palpation of the perineal region including the vagina and/ or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include a vaginal sensor for muscle biofeedback. I understand that this evaluation and/ or treatment could potentially elicit pain or discomfort, but can be stopped at anytime if I request so.

Treatment may include, but not limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/ or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction. Treatment may also include:_____

_____

I understand that no guarantees have been or can be provided regarding the success of therapy. I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists Karen Bailey, PT and/ or Samantha Stollberg, PT PRPC

Patient Name:_____ Date:_____
(please print)

Signature:_____

Signature of Parent/ Guardian if applicable):_____

Witness Signature:_____

820 East Enos Drive Santa Maria, CA 93454 (805) 928-8257 FAX (805) 349-7206 www.smvpt.com

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HEALTH SCREENING QUESTIONNAIRE

Name:_____ Date:_____ Age:_____

Check of any/ all of the specific problems or conditions you now have or have ever had. Explain all responses that are checked and include the date problem began.

MEDICAL HISTORY

- ☐ High Blood Pressure _____
- ☐ Diabetes _____
- ☐ Neurological _____
- ☐ Multiple Sclerosis _____
- ☐ Stroke _____
- ☐ Head Injury _____
- ☐ Allergies _____
- ☐ Latex Sensitive or allergy _____
- ☐ Smoking habit _____
- ☐ Other _____

_____

_____

Date of last pelvic/ prostate exam

_____

Other tests

_____

- ☐ Cancer _____
- ☐ Asthma _____
- ☐ Emphysema _____
- ☐ COPD _____
- ☐ Heart Disease _____
- ☐ Broken bones _____
- ☐ Joint problems _____
- ☐ Low back pain _____
- ☐ Sciatica _____
- ☐ Sexually Transmitted Disease _____
- ☐ HIV/ AIDS _____
- ☐ Osteoporosis _____
- ☐ Date of last urinalysis

_____

SURGICAL HISTORY

- ☐ Back/ spine _____
- ☐ Brain _____
- ☐ Female organs _____

Other please explain

_____

_____

- ☐ Bladder _____
- ☐ Prostate _____
- ☐ Abdominal organs _____

Other please explain

_____

_____

☐

OB/ GYN HISTORY

- ☐ Childbirth vaginal deliveries # _____
- ☐ Episiotomy # _____
- ☐ C- Section # _____
- ☐ Difficult Childbirth # _____
- ☐ Pelvic organ prolapse _____

Other please explain

_____

- ☐ Vaginal Dryness _____
- ☐ Painful periods _____
- ☐ Menopause _____
- ☐ Painful vaginal penetration _____
- ☐ Pelvic pain _____

HEALTH SCREENING QUESTIONNAIRE (CONTINUED)

BLADDER/ BOWEL HISTORY

☐	Trouble initiating urine stream	_____	☐	Trouble emptying bladder completely	_____
☐	Childhood bladder problems	_____	☐	Recurrent bladder infections	_____
☐	Constant dribbling of urine	_____	☐	Constipation/ straining for movement	_____
☐	Blood in urine	_____	☐	Trouble holding back gas/ feces	_____
☐	Urine hesitancy/ slow stream	_____	☐	Trouble feeling bowel/ urge/ fullness	_____
☐	Trouble feeling bladder urge/ fullness	_____	☐	Difficulty stopping the urine stream	_____
☐	Dribbling after urination	_____	☐	Straining or pushing to empty bladder	_____

Other please describe _____

Explain all yes responses _____

_____

_____

MEDICATION	START DATE	REASON FOR TAKING

Are you receiving any other treatment for this condition?

_____

_____

_____

_____

_____

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SYMPTOM QUESTIONAIRRE

Name:_____ Date:_____

1. Describe your main problem. _____

   _____.

2. When did your bowel or bladder problem first begin? _____

   Months ago_____ years ago_____

3. Was your first episode of the problem related to a specific incident? _____YES _____NO

   Please describe and specify date_____

   _____

4. Since that time, is it :
   Staying the same_____ Getting worse_____ Getting better_____

   Why or how? _____

   _____

5. Frequency of urination: awake hours_____times per day_____

   sleep hours_____times per night_____

6. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?

   _____minutes _____hours _____not at all

7. The usual amount of urine passed is _____small_____medium_____large

8. Frequency of bowel movements_____times per day_____times per week or _____

9. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?

   _____minutes_____hours_____not at all_____

10. Average fluid intake (one glass is 8 oz or one cup)_____glasses per day

    Of this total how many glasses are caffeinated_____glasses per day

11. Rate the feeling of organ "falling out" or pelvic heaviness/ pressure:
    _____None present
    _____Times per month (specify if related to activity or your period)
    _____With standing for_____minutes or_____hours
    _____With exertion or straining
    _____Other_____

SKIP TO QUESTION #16 IF NO LEAKEAGE

12a. Bladder leakage-# of episodes
_____No leakage
_____Times per week
_____Times per month
_____Only with physical exertion/ cough

12b. Bowel leakage-# of episodes
_____No leakage
_____Times per week
_____Times per month
_____Only with physical exertion

13a. On average, how much urine do you leak?
_____No leakage
_____Just a few drops
_____Wets underwear
_____Wets outerwear

13b. How much stool do you loose?
_____No leakage
_____Stool staining
_____Small amount in underwear
_____Complete emptying

14. What form of protection do you wear? (Please complete only one)
_____None
_____Minimal protection (Tissue paper/ paper towel/ panty shields)
_____Moderate protection (absorbent product, maxi pad)
_____Maximum protection (Specialty product/ diaper)

15. On average, how many pad changes are required in 24 hours?_____# of pads.

16. Activities/ events that cause your symptoms'. Check all that apply
☐ Strong urge to go
☐ Walking to the toilet
☐ Changing positions(example sit-stand)
☐ No activity changes the problem
☐ With cough/ sneeze/ laugh/ yell
☐ Vigorous activity or exercise(running, weight lifting, jumping)
☐ Light activity(walking, light housework)
☐ Sexual activity
☐ Other, please list _____

_____

17. How has your lifestyle/quality of life been altered or changed because of the problem?
Please respond to all that apply.
_____Social activities (exclude physical activity) specify_____
_____Diet / Fluid intake, specify_____
_____Physical activity, specify_____
_____Work, specify_____
_____Other_____

18. Rate your feelings as to the severity of this problem from 0- 10 with 0 being no problem and 10 being the worst._____

SHORT-FORM McGILL PAIN QUESTIONNAIRE

Patient name: _____ Date: _____

	None	Mild	Moderate	Severe
Throbbing	(0) _____	(1)_____	(2) _____	(3) _____
Shooting	(0) _____	(1)_____	(2) _____	(3) _____
Stabbing	(0) _____	(1)_____	(2) _____	(3) _____
Sharp	(0) _____	(1)_____	(2) _____	(3) _____
Cramping	(0) _____	(1)_____	(2) _____	(3) _____
Gnawing	(0) _____	(1)_____	(2) _____	(3) _____
Hot-Burning	(0) _____	(1)_____	(2) _____	(3) _____
Aching	(0) _____	(1)_____	(2) _____	(3) _____
Heavy	(0) _____	(1)_____	(2) _____	(3) _____
Tender	(0) _____	(1)_____	(2) _____	(3) _____
Splitting	(0) _____	(1)_____	(2) _____	(3) _____
Tiring-Exhausting	(0) _____	(1)_____	(2) _____	(3) _____
Sickening	(0) _____	(1)_____	(2) _____	(3) _____
Fearful	(0) _____	(1)_____	(2) _____	(3) _____
Punishing-cruel	(0) _____	(1) _____	(2) _____	(3) _____

Please make an "X" on the line below to show how bad your pain is right now.

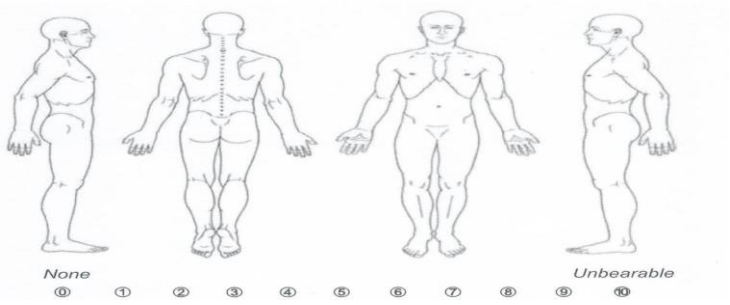
No pain |----------| Worst possible pain

A. Please check the one descriptor that best describes your present pain.

0 No pain _____
1 Mild _____
2 Discomforting _____
3 Distressing _____
4 Horrible _____
5 Excruciating _____

B. Is your pain? (check one word) Brief _____ Intermittent _____ Continuous _____

Please indicate location of pain:



S=___/33 A=___/12

PFDI-20 Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the **last 3 months.**

The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response from 0-4.

Symptoms present= Yes, scale of bother

1= Not at all
2= Somewhat
3= Moderately
4= Quite a bit

Symptoms Not present= NO

0= Not present

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6):

Do you.....	No	Yes
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal Distress Inventory 8 (CRAD-8):

Do you.....	No	Yes
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary Distress Inventory 6 (UDI-6):

Yes	No	Yes
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a strong sensation of need to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20:

Scale Scores: Obtain the mean value of all the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PFSI-20 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0-300).